THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

JUL 26 2001

HEALTH AFFAIRS

Honorable Bob Stump
Chairman, Committee on Armed Services
House of Representatives
Washington, DC 20515-6035

Dear Mr. Chairman.

The enclosed report is submitted in response to the Conference Report accompanying the Emergency Supplemental Act, 2000, House Report 106-710. The Department is required to report on the extent and scope of any violations of fiscal law or departmental regulations with regard to the Defense Health Program (DHP). To date, we did not identify any instances where the DHP made obligations in excess of or in advance of appropriations, nor any violation of Department financial management regulations.

I regret the delay in completing this report and forwarding it to you. Thank you for your continued interest in the Military Health System.

Sincerely,

J. Jarrett Clinton, MD, MPH
Acting Assistant Secretary

Enclosure.
As stated

cc:
Honorable Ike Skelton
Ranking Democrat

Report to Congress

Report to Congress on Anti-Deficiency Act

Review of DHP

REPORT TO CONGRESS ON ANTI-DEFICIENCY ACT REVIEW OF THE DEFENSE HEALTH PROGRAM (DHP)

Introduction

Fiscal Year 2000 presented the Military Health System (MHS) with unprecedented challenges in terms of operating and funding its health care system. Fiscal Year 1999 had been a year of austere funding requiring both an amended President's Budget, internal Defense Health Program (DHP) suppressions, and a supplemental appropriation. In Fiscal Year 2000, the Emergency Supplemental appropriations Act, 2000 (Public Law 106-246) provided more than $1.3 billion to address the critical shortfall confronting the MHS. Of that amount, not to exceed $615.6 million was provided to finance unanticipated increases in TRICARE contract costs for Fiscal Years 1998 through 2001. An additional $695.9 million, with three year obligational authority, was provided to address other DHP funding requirements. In concert with providing additional funding for the DHP, the conference report accompanying the Emergency Supplemental requested two actions:

1) that the DoD Inspector General, in coordination with the General Accounting Office, conduct an investigation into the execution and administration of DHP funds for violations of the Anti-Deficiency Act, evasion of DoD financial regulations, and overall management of the TRICARE Program;

2) that the Department provide a report to the congressional defense committees regarding the extent and scope of any violations of fiscal law or departmental regulations.

This conference agreement reflected a recognition that (1) additional funds were needed to adjust current and prior year obligations to pay managed care support contractors, and (2) additional funds were needed for other contract and military treatment facilities requirements. Section 105 appropriated, in addition to other funds appropriated in the Fiscal Year 2000 Defense Appropriations Act, $615.6 million to the DHP to remain available until September 30, 2001. Section 106(a) (1) of the Emergency Supplemental Act further provided that not to exceed $90.3 million of this amount was to be available for obligations and adjustments to obligations to cover unanticipated increases in TRICARE contract costs of the DHP for Fiscal Year 1998 or Fiscal Year 1999. Section 106 (a) (2) provided that obligations not to exceed $525.3 million was to be available for obligations and adjustments to cover unanticipated increases in TRICARE contract costs of the DHP for Fiscal Years 2000 and 2001. Funds appropriated in Section 107 were intended to address additional unfunded requirements of the DHP.

Background

By the beginning of Fiscal Year 2000, the TRICARE Program was firmly established in the MHS, and the Department was experiencing many of the health care management challenges facing the civilian sector. The TRICARE managed care support (MCS) contractors were experiencing the same types of marketplace pressures the civilian sector was experiencing in terms of cost increases, particularly for prescription drugs. With seven MCS contracts in place within a span of three years, there were large numbers of TRICARE benefit changes occurring, and refinements to the program were necessary. As a result, a backlog was building within the MHS of contract change orders, requests for equitable adjustment, and claims for unanticipated health care contract costs. Due to the complexities of the issues involved, both the government

and the contractors had difficulties developing and evaluating the extensive data required to support settlement of these contract claims.

Additionally, the Department made a decision, as authorized by Congress, to extend some MSC contracts that were scheduled to expire for an additional two years in order to allow the Department to determine the best contracting mechanism for the next generation of TRICARE MCS contracts, and there were unanticipated costs associated with the extensions of these contracts.

Global Settlement

Global Settlement is a process by which all or most unresolved contractor claims against the government, arising from performance to date under the TRICARE MCS contracts, can be aggregated and brought to closure through a negotiated settlement. These settlements reasonably represent the government's liability and the contractor's entitlement to equitable adjustment under the terms of the contract. The goal of Global Settlement was to resolve outstanding claims through validation of the government's liability and negotiation of the quantum of liability based on certified cost and pricing data. The process would also enable the government "to wipe the slate clean" before beginning implementation of the many benefit changes brought about by the Fiscal Year 2001 Floyd D. Spence National Defense Authorization Act or before migration to a new contract model. The government teams, consisting of contracting officers and technical/financial experts/consultants, evaluated the claims and supporting data, entered into discussions to clarify/resolve issues, and formulated a negotiation strategy for a fair and reasonable settlement of the claims. Prior to final negotiation of each settlement agreement, sufficient funding was determined to be available. This approach was a good business decision

for the government and was supported by the TRICARE MCS contractors. Some of the funding provided in the emergency supplemental was used to fund the Global Settlement. Additional funding was borrowed from Fourth Quarter in Fiscal Year 2001 available funds, with the expectation and commitment from the Department that additional funding would be provided through a reprogramming or request for supplemental pending the Department's strategy review.

This report reviews the processes the Department and the DHP use to track financial compliance with congressionally appropriated funding levels, and the Department's experience of executing within appropriated funding levels since the creation of the DHP in FY1991

We have not identified any obligation made in excess of amounts appropriated for the DHP or a failure to comply or in advance of such appropriations with the Anti-Deficiency Act or any Department financial regulation.

DHP Appropriation

The DHP is a separate appropriation within the Department. Congress appropriates funding to support Military Health System (MHS) beneficiaries in three budget activities within the DHP: Operations and Maintenance (O&M); Research, Development, Test and Evaluation (RDT&E); and Procurement. Within each budget activity, funding is further stratified within eight sub-activities to allow specific tracking of major health programs. The eight budget activity group/program element codes for the O&M appropriation include: BAG 1/In-house Care, BAG 2/Private Sector Care, BAG 3/Consolidated Health Support, BAG 4/Information Management, BAG 5/Management Activities, BAG 6/Education and Training, BAG 7 Base Operations/Communications, and BAG 8/Pharmacy.

The fact that the DHP is separate from all other Department funding allows the Department to exercise financial controls over DHP appropriated funding directly via the senior leadership at the TRICARE Management Activity (TMA). As the operational manager of the Military Health System (MHS), under the supervision and policy guidance of the Assistant Secretary of Defense (Health Affairs), this appropriation is managed in accordance with congressional direction and the DoD Financial Management Regulation (FMR). The following sections detail how the Department supports the issuance and execution of the DHP Appropriation within the congressionally appropriated funding.

DHP Funding Process

As the DHP appropriation holder, TMA manages the appropriation and receives annual funding and obligational authority from the Office of Management and Budget (OMB) through the Under Secretary of Defense (Comptroller) following passage of the annual appropriations Act. Funding guidance is issued to the medical components (Army, Navy and Air Force medical departments and TMA). TMA receives funds for operations, centrally procured Information Management/Information Technology (IM/IT), and for centrally managed private sector health care purchased on behalf of the Military Departments. The annual funding guidance document, issued by the Director, Resource Management, TMA details specific operating instructions regarding funding, new programs, and congressional requirements.

Annual funded program and quarterly obligation authority is issued by OMB based on phasing of DHP requirements by the components. The Department's Program Budgeting Accounting System (PBAS), a secure, electronic funding database, is used to control the issuance of annual funded program and quarterly obligational authority. The Funding Authorization Document issued to the various components contains detailed controls and instructions,

iden ify funded floors funded lings and other miscellaneous instructions pertinen execution of these funds. This addition to the written fundin guidance memorandum. C ponent conform to the obligational utho le uthorized instructed U .C. Sec Anti De ency Act ubsequentl the Service components ssue funding/obligational authority their respecti Military Treatment Facilities (MTFs) and other acti ities to support the MHS Funding al ssued by TMA components support central MHS opera onal req uch as nformat managemen for the MHS purchased health care

The DHP hases from the pri ate sector primarily through the five Managed Care uppo Contractors to igmen the direc te Fundin for these at-risk contracts controlled through ystem of funds reservation for the costs of the baseline contract, baseline adjustments, and contract changes. Obligations of these reserved funds occur contract opti ised, adj tmen to the baseline calculated and greed to. ontract modification definitized Based historical perience, "wedge of three per cent of baseli costs is budgeted for program requirement changes.

DoD Accounti Structure

The DHP utilizes the Defense Finance and Accounting Service (DFAS) to record and track funding, obligations and penditures of appropriated funds. The components utilize Service specifi FMR-directed accounting systems to manage the DHP funds issued by the TMA Obligations are recorded dail and liquidated hen disbursement is made by DFAS disbursements and obligations reconciled. Accounting reports monitoring DHP penditures prepared dail and reported monthly the Department. Army DHP bligations reported by DFAS dianapoliv N. DHP obligations are reported by

DFAS-Cleveland; and Air Force DHP obligations are reported by DFAS-Denver. TMA accounting is performed by DFAS-Indianapolis. At the end of each month, DFAS-Indianapolis consolidates the data into a consolidated level report, Department of Defense Comptroller Report, 1002 (DD Comp(M) 1002). This monthly obligation data report is the basis for the preparation of the monthly Department level certification of obligations to the Department of Treasury. This monthly reporting of conformance to appropriated quarterly and annual budget authority is the DHP's evidence of compliance with statutory requirements and the Department's financial management regulations.

TMA manages its own Defense Health Program Resource Database (DHPRDB) that uploads monthly DFAS data at a greater detail than the Department's 1002 reporting makes available. Historical data are used throughout the DHP in building Program Objective Memorandum (POM), Budget Estimate Submission (BES), and President's Budget (PB) requirements. Current year data are used to validate current year execution in TMA appropriation-wide quarterly reviews.

Funds Control Management

The TMA, as appropriation manager for the DHP, has established a management overview process wherein the components are instructed on program execution of all funds as required by the FMR. The TMA and component senior resource managers meet semi-monthly as the Resource Management Steering Committee (RMSC). The RMSC is an executive level resource management board comprised of the Deputy Director Resource Management for TMA and Service medical component senior resource managers who discuss matters of budget formulation and execution, with formal execution reviews held quarterly. As required by the FMR, the DHP formal quarterly execution reviews are conducted to review component spending against annual

obligational authority. Any significant deviations from the annual plan must be justified by the components. Additionally, programs that are in jeopardy of over-executing are identified, analyzed and corrected. In turn, the components each have their own Planning, Programming Budgeting System (PPBS) and appropriate financial management committees at every level where funding is received (headquarters, base level/MTF). These monthly and quarterly financial reviews allow for detailed analysis and corrective actions to ensure compliance with congressional direction, Departmental financial requirements, and financial management regulations.

TMA utilizes several briefings as management tools to inform the Department's senior medical leadership including the Assistant Secretary of Defense (Health Affairs), the TMA Executive Director, the Service Surgeons General, OUSD (Comptroller) staff and Office of Management and Budget (OMB). These briefings afford an opportunity to review performance and provide the basis for any necessary funding adjustments or to resolve DHP financial issues.

Anti-Deficiency Act (ADA) Compliance

Since creation of the DHP in 1991, the DHP has never exceeded its quarterly or annually appropriated funding levels. In recent years, most notably Fiscal Years 1997, 1998, 1999 and 2000, the DHP required additional funding in order to continue MHS operations. Early identification of these shortfalls and subsequent funding, either internally by the Department or by Congress, along with management actions taken to reduce obligations, provided funding sufficient to continue program operation. Without the additional funding the Department would have had to implement numerous management actions. The DHP and TMA funding practices have been reviewed by external agencies. For instance, the General

Accounting Office (GAO) conducted an evaluation of DHP funding obligational adjustments in 1999 (GAO/HEHS-99-79 DEFENSE HEALTH PROGRAM: Reporting of Funding Would Assist Congressional Oversight). While the purpose of this audit was to examine the DHP's movement of appropriated funding within the DHP sub-activity groups, the GAO found no evidence of any violation of fiscal law or Department regulation. However, the GAO recommended that Congress consider requiring DoD, consistent with current notification standards and procedures, to notify the congressional defense committees of its intent to shift funding among sub-activities such as direct care, purchase care, or base operations. Also, the GAO recommended that Congress consider requiring DoD to provide congressional defense committees with quarterly budget execution data and DHP O&M accounts similar to the data provided to Congress for the non-DHP accounts.

The result of these recommendations was an agreement that the Under Secretary of Defense (Comptroller) would provide monthly Department of Defense Comptroller Report, 1002 (DD Comp(M) 1002) by sub-activity for the DHP to the congressional defense committees as part of its submission of data for O&M accounts. Secondly, the Department agreed to brief the congressional defense committees on the status of the DHP as frequently as desired to ensure the committees are fully informed.

DoD Inspector General Audit

The Department of Defense Inspector General (DoD IG), in coordination with the GAO, conducted an audit of DHP funds administered as part of the TRICARE program. An April 30, 2001, audit report has been provided to appropriate Congressional Committees through the normal reporting route. The DoD-IG audit addresses the use of the emergency supplemental funding, which is summarized on Attachments 1 and 2.

Conclusion

The Department has implemented several measures to preclude future funding difficulties. As one example, the TMA has modified the process of incorporating changes into the $4 billion managed care support contracts that provide the contract care portion of the MHS health care delivery. These contract changes will ensure that modifications to the contracts are identified in a timely manner, reviewed by a Change Order Board, are negotiated fairly to ensure the best value for the Department, and are incorporated into the Department's budgeting process prior to implementation.

The Department's review of TMA financial management and the Inspector General's audit report of April 30, 2001, did not identify any obligations made in excess of amounts appropriated to the DHP or in advance of such appropriations or a failure to comply with any Departmental financial management regulations. Additionally, GAO has recently reviewed the department's practices in obligating DHP funds for medical service and related contractor-provided administrative services and has formed such practices to be consistent with GAO holdings (Attachment 3).

Attachment 1

Section 105/Two year funds

Contract Modification By Region	Mod Date	Fiscal Year	Amount (M)	Some issues included in settlement
Region 6 Pharmacy BPA	8/24/00	FY00	103.480	
Region 9/10/12 Option Period 5	8/29/00	FY00	194.785	
Region 9/10/12 Option Period 5	8/29/00	FY00	5.215	
Regions 3/4 BPA 3	3/6/00	FY00	27.103	
Regions 3/4 BPA 3	3/6/00	FY99	12.500	
Regions 3/4 BPA 3	3/6/00	FY98	3.612	
Regions 3/4 BPA 4a	9/29/00	FY00	78.606	pharmacy BPA
Regions 3/4 BPA 4a	9/29/00	FY99	4.624	
Regions 7/8 Resource Sharing	9/12/00	FY00	8.787	
Regions 7/8 Pharmacy BPA	12/15/00	FY01	29.203	
Region 1 BPA 8	12/18/00	FY00	3.199	
Regions 3/4 Excess Claims	11/22/00	FY00	1.241	
Regions 9/10/12 Global Settlement	1/5/01	FY98	4.197	
Regions 9/10/12 Global Settlement	1/5/01	FY99	8.915	AD service member newborns, telephone consults
Regions 9/10/12 Global Settlement	1/5/01	FY00	12.742	
Region 11 Global Settlement	1/5/01	FY98	2.155	
Region 11 Global Settlement	1/5/01	FY99	2.353	telephone consults, meridian audits, pharmacy BPA
Region 11 Global Settlement	1/5/01	FY00	6.158	
Region 6 Global Settlement	1/5/01	FY98	8.488	
Region 6 Global Settlement	1/5/01	FY99	7.468	telephone consults, meridian audits, AD service member newborn
Region 6 Global Settlement	1/5/01	FY00	12.215	
Regions 7/8 Global Settlement	1/17/01	FY98	4.132	
Regions 7/8 Global Settlement	1/17/01	FY99	13.388	telephone consults, meridian audits
Regions 7/8 Global Settlement	1/17/01	FY00	9.570	
Regions 2/5 BPA 4-8	1/29/01	FY00	7.153	
Regions 7/8 Global Settlement	1/12/01	FY00	5.013	
Regions 2/5 Global Settlement	2/1/01	FY00	8.879	CPIRI, mental health
Regions 3/4 Excess Claims	2/1/01	FY98	4.755	
Regions 3/4 Eligibles/case mix	4/12/01	FY98	7.260	
Regions 3/4 Eligibles	4/12/01	FY99	6.453	
Regions 3/4 Eligibles	4/12/01	FY00	11.951	
		Total Items	615.600	

Summary by FY:

FY98: 34.599
FY99: 55.701
FY00: 496.097
FY01: 29.203
Total: 615.600

Attachment 2

Section 107/Three year funds

Contract Modification By Region	Mod Date	Fiscal Year	Amount (M)	issues included in settlement
Regions 7/8 BPA4		FY00	10.458	commitment
Region 6 BPA 6	12/21/00	FY00	11.199	
Region 2/5 settlement		FY00	8.200	
Region 9/10/12 OP5	8/29/00	FY00	22.385	
Regions 7/8 Pharmacy BPA	12/15/00	FY01	10.885	
Regions 7/8 Pharmacy BPA	12/15/00	FY01	7.727	
Region 1 BPA8	12/18/00	FY00	11.697	
Region 6 BPA 6- interim pmt	10/6/00	FY00	31.653	
Regions 9/10/12 Global Settlement	1/5/01	FY00	25.999	ADSM NB & Telecon
Region 6 Global Settlement	1/5/01	FY00	19.436	Telecon, Meridian Audit, ADSM NB
Region 1 Global Settlement	1/9/01	FY00	9.444	Change orders
Regions 7/8 Global settlement	1/17/01	FY00	10.436	MTF Outpatient
Region 1 Global settlement	1/9/01	FY01	2.110	
Regions 2/5 BPA 4-8	1/29/01	FY00	27.081	
Regions 2/5 Global settlement	2/1/01	FY00	3.973	CPIRI, Mental Health
Regions 3/4 Excess Claims	2/1/01	FY00	12.241	
Regions 7/8 OP5	3/16/01	FY01	26.260	
Regions 3/4 Global settlement	4/12/01	FY00	10.651	
Regions 7/8 BPA4		FY00	6.411	commitment
Regions 3/4 Global settlement	4/12/01	FY01	48.800	mental health, CPIRI
	Sub Total		317.046	
Proposed Mods				
Misc Changes Outside global		FY00	32.888	commitment
Misc Changes Outside global		FY01	43.671	commitment
FY00 Future BPAs		FY00	67.852	commitment
FY01 Future BPAs		FY01	90.143	commitment
FAD to Services		FY00	144.300	
	Sub Total		378.854	
	Total Items		695.900	

Summary by FY:

FY00: 466.304

FY01: 229.596

Total: 695.900

GAO
Accountability * Integrity * Reliability
United States General Accounting Office
Washington DC 20548

B-287619

July 5, 2001

The Honorable Jerry Lewis
Chairman, Subcommittee on Defense
Committee on Appropriations
House of Representatives

Dear Mr. Chairman:

This responds to your inquiry of April 4, 2001, concerning the legal requirements for recognizing and recording obligations under the Defense Health Program (DHP). You asked us to examine the legal basis for obligations incurred by TRICARE Management Activity for, among other services, medical services provided directly by DOD to beneficiaries as well as medical services provided by civilian contractors who subsequently bill DHP for those services. You also asked us to examine the legal basis for obligations for costs of change orders or other negotiated settlements. Finally, you asked whether the Antideficiency Act applies to DHP obligations and expenditures.

By letter dated May 3, 2001, we asked the Acting Assistant Secretary of Defense for Health Affairs for information on DHP's obligations and DHP's views on the legal issues presented. On June 22, 2001 the Acting Assistant Secretary of Defense for Health Affairs responded to our request. (DOD response). We have incorporated information provided by DOD's response as appropriate throughout this opinion.

In the discussion that follows we have set out the general rules for obligating funds for the medical services provided to beneficiaries and contractor provided services, and we conclude that DOD's practices in obligating funds are consistent with our holdings. For the reasons explained below, we conclude that due to DOD's legal liability for providing medical services to eligible beneficiaries, DOD may enter into obligations in excess of available budgetary resources without violating the Antideficiency Act. While DOD may enter into obligations in excess of available budgetary resources, it must obtain appropriations sufficient to liquidate those obligations.

BACKGROUND

Defense Health Program

The Department of Defense's (DOD) primary medical mission is to maintain the health of active duty service members in peacetime and during military operations. DOD also provides health care to other individuals, including dependents of active duty members, military retirees and their dependents.[1] DOD's health program, known as TRICARE, provides medical care to eligible beneficiaries through a combination of direct care and civilian provided care. DOD provides direct medical care through its military hospitals and clinics, known as military treatment facilities (MTFs). Medical services provided at MTFs include outpatient and inpatient care for medical and surgical conditions, pharmacy services, physical examinations, dental care, and diagnostic, laboratory and radiological tests and services.

DOD supplements direct care with contracted civilian medical care. The TRICARE program provides beneficiaries with a choice among a health maintenance organization (TRICARE Prime), a preferred provider network (TRICARE Extra), and a fee-for-service benefit (TRICARE Standard). DOD contracts with managed care support contractors to administer its TRICARE program on a regional basis, which presently consists of seven contracts covering eleven geographic TRICARE regions. The TRICARE contracts consist of a base period and five option years.[2] The TRICARE contractors perform administrative services, such as developing civilian provider networks, verifying provider credentials, negotiating reimbursement discounts, enrolling beneficiaries, referring and authorizing beneficiaries for health care, and processing health care claims. DOD awarded the TRICARE contracts as fixed-price, at-risk contracts in which the contractor assumes liability for payment of medical services subject to the requirements of the contract. The at-risk care refers to the civilian health care services provided under a fixed price arrangement in which the contractor approves and makes payment to the provider or beneficiary. The other arrangement is referred to as not-at-risk care or pass through costs. For payment of pass through costs, the contractor provides information to DOD to seek approval for payment. If DOD approves payment, the contractor is notified to pay the claim.

TRICARE is managed at multiple levels. Congress appropriates funds for the Defense Health Program's operation and maintenance (O&M), procurement, and research,

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[1] For ease of reference and consistent with DOD regulations, we refer to active duty members and their dependents, military retirees and their dependents as beneficiaries of DOD's health program. See 32 C.F.R. § 199.2(b).

[2] The base period, which varies by contract, consists of a transition period, ranging from 6-9 months, and the early months of health care delivery.

development, test and evaluation (RDTE) expenses.[3] See Department of Defense Appropriations Act, 2000, Pub. L. No. 106-79, 113 Stat. 1212, 1228 (1999). DHP appropriations are used to pay the costs of providing medical care in the MTFs, purchasing care from civilian medical providers and paying TMA contractors for administrative services. The Office of the Assistant Secretary of Defense for Health Affairs sets policy for MTFs and civilian provided medical care and establishes regulations in coordination with the Army, Navy and Air Force. The TRICARE Management Activity (TMA) is delegated responsibility for policy execution, shared with the military Surgeons General who are responsible for implementing TRICARE policy within their respective services. TMA performs program-wide support functions, such as managing TRICARE's information technology and data systems, preparing the budget and managing the accounts. TMA selects, directs and pays managed care support contractors, who maintain the civilian provider network and perform services assisting beneficiaries and management of the program. In each TRICARE region within the United States, a lead agent coordinates MTF and contractor activities; usually the commander of the region's largest MTF. The MTF commanders report to the Surgeon General of their respective service who allocates part of the service's appropriated funds to each MTF. MTF officials have input into private provider network size and composition but lack direct authority over the providers or the network, which is managed by the managed care support contractor.

Active duty military members are automatically enrolled in TRICARE Prime and their dependents also may enroll in TRICARE Prime without paying an enrollment fee. Military retirees and their dependents must pay an enrollment fee to join TRICARE Prime. Enrollees do not have to meet an annual deductible. An enrollee chooses a Primary Care Manager who is the primary physician that provides or coordinates all healthcare for that enrollee. When an enrollee receives medical care directly from an MTF, there is no copayment and the costs of providing care are part of the costs of operating the MTF. Medical care under TRICARE Prime is usually provided in MTFs, but civilian provided care is used when a Primary Care Manager refers an enrollee for such care.

Participating civilian medical providers join a network managed by the TRICARE contractors where they are paid for services provided in accordance with a negotiated reimbursement rate. If enrollees go to a Prime civilian provider, the provider submits the claim for reimbursement to the TMA contractor. Active duty military members and their dependents do not pay a copayment for civilian provided services except for pharmacy services and services under the Program for Persons with Disabilities. Military retirees and their dependents, on the other hand, pay a fixed dollar amount as copayment for civilian provided services. A TRICARE Prime enrollee may also use civilian provided care without requesting a referral from their Primary Care Manager under the Point of Service Option. Under the Point of Service

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[3] In addition to the DHP appropriations, Congress appropriates military personnel and military construction funds to cover those costs of the military health program. Civilian personnel costs are paid from the DHP O&M appropriation.

Option, the requirements of TRICARE Standard described below, such as deductibles and cost sharing, apply.

TRICARE Extra functions as a preferred provider option in which participating civilian medical providers join a network managed by the TRICARE contractors. The participating civilian medical providers are paid for services provided in accordance with a negotiated reimbursement rate. Under TRICARE Extra, beneficiaries pay less than they would if using non-network providers. Medical providers who do not join the network may provide care under TRICARE Standard, a fee for service option, for which they are reimbursed up to a maximum rate established for the service provided.[4] Under TRICARE Standard medical providers can bill the beneficiary for up to an additional 15 percent above the established rate. Under TRICARE Extra and TRICARE Standard, beneficiaries do not have to enroll or pay enrollment fees, but they must pay a deductible each year and are responsible for cost sharing, that is, the copayment or amount of money for which the beneficiary is responsible.

The reimbursement process for civilian provided care is essentially the same under the three TRICARE options. When a beneficiary receives medical care from a civilian medical provider, the provider submits a claim for reimbursement to the TRICARE contractor for adjudication in accordance with DOD regulations. 32 C.F.R. Part 199. A beneficiary, who has paid the health care provider directly for medical services, may submit a claim for reimbursement for services provided. For the payment of care that is at-risk, the TRICARE contractor reviews the claim to verify the eligibility of the beneficiary, determine whether the medical services provided are allowable, and determine the amount to be paid. Once the TRICARE contractor adjudicates and settles a claim, the contractor issues a check to the claimant. For payment of care that is not at-risk, referred to as "pass through", the contractor transfers information electronically to seek approval from DOD for payment. If DOD approves payment, the contractor is notified to release payment. If a claim is denied, medical providers and beneficiaries may appeal the determination. 32 C.F.R. § 199.10.

ANALYSIS

Recognition and Recording of Obligations for Medical Services and Related Contractor Provided Administrative Services

Medical Services

Under 31 U.S.C. § 1501(a), an amount should be recorded as an obligation against an available appropriation when supported by documentary evidence of a legal liability of the government. As explained below, we believe that DOD's practices in obligating

[4] Prior to TRICARE, DHP implemented the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), which like TRICARE Standard, was the equivalent of a health insurance plan that reimbursed beneficiaries for portions of the costs of health care received from civilian providers.

funds are consistent with our holdings. With respect to direct care, DOD determines a beneficiary's eligibility for treatment, the type of treatment to be provided and incurs the costs of treatment. For direct care, DOD's costs are the expenses of operating the MTFs, such as paying the costs of acquiring supplies, paying employees and other related expenses of operating the facilities. The rules for recognizing obligations for these costs are the same as those applicable to typical internal agency operations. As a general rule, supplies acquired for use during the current fiscal year are a bona fide need of that year and are chargeable to the current fiscal year's appropriation. 60 Comp. Gen. 361 (1981). Costs such as paying employees are obligations at the time the salaries are earned, that is, when the services are rendered, generally on a pay period basis. 24 Comp. Gen. 676, 678 (1945). Other costs of operating facilities, such as paying utilities or maintenance services, are generally obligations at the time the services are performed. B-259274, May 22, 1996; 34 Comp. Gen. 459, 462 (1955). Thus, DOD should record those costs as obligations chargeable to the appropriation current at the time the services are provided.[5]

In contrast to the cost of care provided beneficiaries directly through MTFs, both the TRICARE contractors and DOD determine the liability for payment of costs of civilian provided care through the adjudicative process after the medical services are provided in accordance with applicable laws, regulations and DOD policy. For the at-risk payment portion, which is fixed, DOD informed us that it records an obligation when the contracting officer enters into the option period. Where the obligation is fixed, an agency may record the obligation in an amount equal to the least quantifiable amount of the government's liability. See 62 Comp. Gen. 143, 146-147 (1983); 48 Comp. Gen. 497, 502 (1969).

For pass through care, DOD informed us that it records an obligation when DOD approves the payment and notifies the contractor to make such payment. Where an agency has an adjudicative administrative process of review and approval for medical services, the presumption is that the agency is not liable for the costs until a qualified employee has approved and accepted the invoice. 46 Comp. Gen. 895 (1967). The approval of the services constitutes the agency's agreement or legal liability to pay and is the documentary evidence required by 31 U.S.C. § 1501(a). Id. The claims process for payment of civilian provided services does not establish DOD's liability for payment until the TRICARE contractor processes the claim and DOD has determined that the beneficiary is eligible to receive treatment, that the services provided are allowable, and the amount billed is proper. 32 C.F.R. Parts 199.3, 199.4 and 199.7. DOD regulations[6] make medical providers and beneficiaries aware that

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[5] An exception to this rule is provided in 10 U.S.C. § 2410a, which authorizes DOD to use current fiscal year appropriations to finance a severable service contract that continues into the next fiscal year.

[6] DOD regulations for the CHAMPUS and TRICARE programs are found at 32 C.F.R. Part 199. Parts 199.1 through 199.16 contain provisions established for the CHAMPUS program, while Parts 199.17 through 199.22 apply to the TRICARE program. However, the CHAMPUS provisions are also applicable to the TRICARE

(...continued)

such adjudication establishes liability for payment of their claims. Thus, in accordance with 46 Comp. Gen. 895, DOD should record the obligation at the time, and in the amount, of the approved claim. See also, B-133944, January 31, 1958 (Fiscal year appropriation properly charged on monthly basis to cover amounts of bills approved for the costs of prescriptions filled for veterans); B-92679, July 24, 1950 (Cost of emergency hospitalization or medical and dental treatment without prior authorization chargeable to the appropriation current at time the claim for reimbursement is approved).

TRICARE Contractor Services

The services performed by TRICARE contractors in administering the TRICARE program include developing civilian provider networks, verifying provider credentials, negotiating reimbursement discounts, enrolling beneficiaries, referring and authorizing beneficiaries for health care, and processing health care claims. With respect to service contracts, for obligational purposes, the issue is whether a service is severable or nonseverable. B-277165, January 10, 2000. The nature of the services performed determines whether a service is severable or nonseverable. Id. Nonseverable services involve services that represent a single undertaking, or, in other words, provide value when the entire project is complete. Id. Severable services generally involve continuing or recurring services often reflecting the day to day operational needs of an agency. Id. For obligational purposes, agencies should charge the costs of severable services to the appropriation current at the time the services are rendered. Id. The types of services provided by TRICARE contractors, such as ensuring provider credentials, enrolling beneficiaries, referring and authorizing care, and adjudicating claims are severable into components that independently provide value to DOD as performed and meet a separate and ongoing need. See 60 Comp. Gen. 219 (1981) (Technical and management assistance tasks are severable and should be charged to appropriation current at time services are rendered). Thus, DOD should record obligations against the appropriation current at the time the services are rendered.

TRICARE Contracts and Change Orders

Although the TRICARE contracts were awarded as fixed-price at-risk contracts, DOD may make several types of contract adjustments that affect the contract performance and price, namely bid price adjustments, equitable adjustments, and change orders. DOD designed the contracts to include adjustments for health care cost increases beyond the contractors' control, with other costs, such as administrative costs, remaining fixed. These bid price adjustments (BPAs) are based on conditions such as shifts in workload between the MTFs and civilian providers, or changes in the number of beneficiaries due to geographic transfers of active duty members and their

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program, including claims submission and approval requirements, except where TRICARE provisions specifically take precedence over CHAMPUS provisions. See e.g., Part 199.4(a)(ii).

dependents. To calculate such adjustments, DOD uses a formula that includes cost, population shifts, inflation and utilization. TRICARE contractors also initiate requests for equitable adjustments (REAs) to cover unforeseen changes in contract conditions, such as higher than anticipated claim submissions that increase administrative expenses.

Since you asked us to address the obligational requirements for change orders, we will focus on that process. Generally, government contracts contain a Changes clause that permits the contracting officer to make unilateral changes within the general scope of the contract. 48 C.F.R. § 43.201. Change orders are a type of contract modification defined by the Federal Acquisition Regulation (FAR) as " a written order, signed by the contracting officer, directing the contractor to make a change that the Changes clause authorizes the contracting officer to order without the contractor's consent." 48 C.F.R. § 43.101.[7] If a change causes an increase or decrease in the contractor's cost of, or time required for, the performance of work under the contract, the contracting officer must make an equitable adjustment and modify the contract in writing. 48 C.F.R. §§ 52.243-1 (fixed price contract) and 52.243-2 (cost reimbursement contract).

Change orders may result from new laws or regulations, or from DOD initiatives.[8] The TRICARE change orders range in scope from administrative changes, such as changes to billing procedures, to significant benefit expansions, such as addition of a hospice benefit or elimination of copayments for active duty dependents, which could significantly add to program costs. By June 30, 2000, DOD had made a total of over 1,000 change orders to the TRICARE contracts. While DOD had independent government estimates of the cost of the change orders, DOD implemented many of these change orders prior to negotiation of the final terms of the modification including payment terms. Between December 2000 and February 2001, DOD eliminated most of its large backlog of outstanding change orders under a short-term effort using global settlements to settle all outstanding contract adjustments.[9]

The issue of the proper obligation of the costs of change orders cannot be separated from the underlying events triggering the government's liability for medical services provided to beneficiaries and administrative services provided to DOD. The change orders to the TRICARE contracts relate to the nature and amount of medical services

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[7] This section was amended by FAC 97-22, May 11, 2001 to include this definition in 48 C.F.R. § 2.101.

[8] As reported in 1997, the most recent data available to GAO showed that one-third of all TRICARE change orders resulted from new laws or regulations while the remaining two-thirds were self-initiated. Defense Health Care: Actions Underway to Address Many TRICARE Contract Change Order Problems (GAO/HEHS-97-141, July 14, 1997).

[9] Defense Health Care: Continued Management Focus Key to Settling TRICARE Change Orders Quickly (GAO-01-513, April 30, 2001).

provided beneficiaries and to the management of the TRICARE program. For medical services provided to beneficiaries directly from the MTFs, DOD's liability consists of the costs incurred in operating the MTFs and providing medical services to the beneficiaries and those costs should be recorded as discussed above. For medical services provided through civilian contracted care, DOD's liability for at-risk payment is determined by the fixed price established by the contract and should be recorded at the time DOD executes the contract or option. For medical services provided through civilian contracted care, DOD's liability for pass through payment is determined through the adjudicative process after the medical services are rendered. As discussed above, those costs should be recorded at the time of the claim approval. Similarly, for the costs of contractor provided administrative services in carrying out the TRICARE program, DOD should record obligations as those services are rendered. To the extent change orders affect services to be provided in the future, DOD should obligate in accordance with the above rules.

The resolution of the change orders by negotiation or settlement goes to the price of the change orders, i.e., the amount of DOD's liability. 48 C.F.R. § 52.243-4. The negotiated global settlements totaled about $900 million for current and prior fiscal years. We have not audited the amounts related to change orders, BPAs or REAs for services provided during each fiscal year covered by the global settlements nor has DOD advised us as to those amounts.

Prior to DOD finalizing the global settlements, Congress, in July 2000, provided supplemental appropriations of $615,600,000 for the Defense Health Program in amounts not to exceed:

> "$90,300,000 . . . for obligations and adjustments to obligations required to cover unanticipated increases in TRICARE contract costs that (but for insufficient funds) would have been properly chargeable to the Defense Health Program account for fiscal year 1998 or fiscal year 1999; and . . . $525,300,000 . . . for obligations and adjustments to obligations required to cover unanticipated increases in TRICARE contract costs that are properly chargeable . . . for fiscal year 2000 or fiscal year 2001"

Military Construction Appropriations Act, 2001, Pub. L. No. 106-246, § 105-106, 114 Stat. 511, 529 (2000). To the extent the amounts appropriated and otherwise available cover the costs allocable to those years, DOD should so obligate.[10] DOD informed us that when final settlements were reached, contract modifications were issued to incorporate the settlement price and obligations were recorded against the applicable appropriations. To the extent that the amounts appropriated in the supplemental are inadequate to cover those costs, DOD would require additional appropriations from Congress.

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[10] In addition, Congress appropriated $695,900,000 for DHP to remain available for obligation until the end of fiscal year 2002. Pub. L. No. 106-246, § 107, 114 Stat. at 530

Applicability of the Antideficiency Act

The purpose of the Antideficiency Act is to prevent the officers of the government from making or authorizing obligations or expenditures in excess of or in advance of available appropriations. The Antideficiency Act's prohibitions are directed at discretionary obligations incurred by government officers. 65 Comp. Gen. 4, 9 (1985); 39 Comp. Gen. 422, 425 (1959); B-225801, March 2, 1988. The Antideficiency Act specifically provides an exception for obligations authorized by law to be made in excess of or in advance of appropriations. 65 Comp. Gen. at 9.

We have previously identified situations where Congress has expressly mandated an agency to incur obligations without regard to the availability of budgetary resources to cover the obligations. Id. For example, in B-225801, March 2, 1988, we pointed out that the Veterans Administration (VA) becomes legally liable for compensation and pension benefit payments to a veteran on the date it administratively adjudicates a veteran's claim as due and payable. Since no further congressional action is needed to establish a right to payment, the obligation for these benefits occurs by operation of law, and should be recorded under 31 U.S.C. § 1501 regardless of the amount of available budgetary resources at such time. Id. In obligating amounts in excess of available budgetary resources, the agency does not violate the Antideficiency Act. Id. In 65 Comp. Gen. 4 (1985), we held that where Congress authorized the Department of Education to extend loan guarantees in amounts which could at any time far exceed available funding,[11] and then required the Department to promptly pay beneficiaries of those guarantees upon the borrower's default, it expressly authorized the Department to incur obligations in excess of or in advance of appropriations. We noted that the Department's administrative officers did not have any control over the amount the Department would be required to pay under applicable statutory provisions. Id. Thus, the obligation to make payments on the loan guarantees were not discretionary expenses covered by the Antideficiency Act but rather fell within the Antideficiency Act's "unless authorized by law" exception. Id. Similarly, in 39 Comp. Gen. 422 (1959), we held that the administrative action granting pay increases to wage board employees effective on a specified date not only imposed a legal liability on the government to pay additional compensation, but created an obligation against the appropriation current at the time the liability arose regardless of whether the applicable appropriation had sufficient funds.[12]

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[11] Subsequent to the decision in 65 Comp. Gen. 4 (1985), Congress enacted the Federal Credit Reform Act of 1990, as amended, which provides that beginning with fiscal year 1991, for covered loans and loan guarantees, an agency must cover the cost of loan and loan guarantee programs with budget authority. Pub. L. No. 101-508, Title XIII, 104 Stat. 1388-610 (1990).

[12] In the cases noted above, we also held that the agencies would have to request supplemental appropriations to liquidate those obligations if there were insufficient funds to cover those payments.

We think that DHP obligations for medical services fall into the category of obligations mandated by law. Medical services at MTFs are available to beneficiaries according to a statutorily established priority. Active duty members of the armed forces are "entitled to medical and dental care in any facility of any uniformed service." 10 U.S.C. § 1074(a). Dependents of active duty members are "entitled, upon request, to the medical and dental care . . . in facilities of the uniformed services, subject to the availability of space and facilities and the capabilities of the medical and dental staff." 10 U.S.C. § 1076(a)(1). Military retirees "may, upon request, be given medical and dental care in any facility of any uniformed service, subject to the availability of space and facilities and the capabilities of medical and dental staff." 10 U.S.C. § 1074(b).[13] Dependents of military retirees "may, upon request, be given the medical and dental care . . . in facilities of the uniformed services, subject to the capabilities of the medical and dental staff." 10 U.S.C. § 1076(b). However, apart from the medical services available at MTFs, dependents of active duty members, military retirees and their dependents are entitled to receive medical care from civilian providers. 10 U.S.C. §§ 1079 and 1086. In this regard, sections 1079 and 1086 direct the Secretary of Defense to assure by contract that medical care is available for these beneficiaries subject to deductibles and copayments prescribed by law.

While the order of priority for, and the provider of, medical services varies according to the status of a beneficiary, DOD is required to provide medical care to beneficiaries as provided by law. The statutes authorizing the DHP services set forth the beneficiaries' entitlement to medical services, the medical services available, and the limitations on the amounts of deductibles and copayments required for such services. Under these statutory provisions, a beneficiary need only present himself for medical treatment subject to applicable deductibles and copayments; if the statutory requirements are met, DOD must pay for or reimburse the beneficiary or medical provider for those medical services. Thus, we conclude that DHP actions are "authorized by law" regardless of the amount of available budgetary resources and do not violate the Antideficiency Act.[14] To the extent DOD incurs obligations in excess of available budget authority to cover the costs of services required, DOD would need to obtain additional appropriations to cover payments for these obligations.

This opinion does not address DOD's management of the defense health program. For a discussion of some of the challenges DOD faces in managing the defense health program, see Defense Health Care: Lessons Learned From TRICARE Contracts and Implications for the Future (GAO-01-742T, May 17, 2001) and products listed therein.

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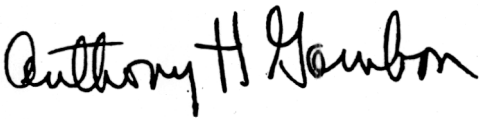
[13] While not in effect during the period relevant to this opinion, Medicare eligible military retirees and dependents will be eligible, under TRICARE for Life, for the same benefits as retirees under age 65. National Defense Authorization Act for Fiscal Year 2001, Pub. L. No. 106-398, 114 Stat. 1654 (2000). However, these changes do not affect our analysis.

[14] While recognizing that the DHP is "essentially an entitlement program", DOD informed us that it is managed in accordance with the Antideficiency Act requirements.

CONCLUSION

DOD should obligate for the medical services provided to beneficiaries and contractor provided services in accordance with the rules described above. Given DOD's legal liability for providing medical services to eligible beneficiaries, we conclude that such actions are "authorized by law" regardless of the amount of available budgetary resources and do not violate the Antideficiency Act. We trust that this responds to your request. Should you have any questions, please contact Mr. Jeffrey Jacobson (202) 512-8261 or Ms. Edda Emmanuelli Perez of my staff at (202) 512-2853.



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